ENROLLMENT AND CHANGE APPLICATION

COMPLETED BY GROUP ADMINISTRATOR ONLY

Effective Date _____ *(mm/dd/yyyy)*

Group Number _____

Package Number _____

Dept/Division/Class _____

☐ **Change Request:** *For changes, complete sections **A**, **B**, and all other applicable sections*

Instructions: ALL new Employees Complete **B**, **C**, **D**, **E**, **G**
If your group has selected any Life Products also complete and provide your signature in **F**
ALL dates should be indicated as (mm/dd/yyyy)

☐ **PLEASE CHECK THIS BOX IF YOU WOULD LIKE SPANISH MATERIALS (WHEN AVAILABLE)**

PLEASE TYPE OR PRINT IN BLACK OR BLUE INK. PRESS FIRMLY.

A. IF MAKING A CHANGE FROM PREVIOUS ENROLLMENT

CHECK ALL THAT APPLY:
- ☐ Name Change
- ☐ Address Change
- ☐ Telephone Change
- ☐ Replace ID Card
- ☐ Date of Birth Correction
- ☐ Open Enrollment
- ☐ Other Insurance Information

ADD DEPENDENT(S): / DATE *(mm/dd/yyyy)* OF OCCURRENCE:
- ☐ Marriage _____
- ☐ Newborn _____
- ☐ Adoption _____
- ☐ Other _____
- _____ _____
- _____ _____
- _____ _____

REMOVE DEPENDENT(S): / DATE *(mm/dd/yyyy)* OF OCCURRENCE:
- ☐ Marriage _____
- ☐ Divorce _____
- ☐ Student Status _____
- ☐ Death _____
- ☐ Other _____
- _____ _____
- _____ _____

CHECK ALL THAT APPLY:
- ☐ ELECT COBRA EFFECTIVE: _____

COBRA QUALIFYING EVENT:
- ☐ Termination of Employment
- ☐ Reduction in Hours
- ☐ Divorce
- ☐ Medicare Eligible
- ☐ Social Security Disability Determination
- ☐ Overaged Dependent Now Ineligible
- ☐ Death

☐ CANCEL COVERAGE

REINSTATE COVERAGE:
- ☐ Return from Layoff
- ☐ Return from Leave
- ☐ Retirement
- ☐ Disenrollment Error
- ☐ Other
- _____
- _____
- _____

B. EMPLOYEE INFORMATION

☐ Active Employee ☐ COBRA/State Continuation: | DATE CONTINUATION STARTED (mm/dd/yyyy) ___/___/___ | DATE CONTINUATION ENDS (mm/dd/yyyy) ___/___/___

FIRST NAME/MIDDLE INITIAL	LAST NAME	EMPLOYEE SOCIAL SECURITY NUMBER	EMPLOYEE BIRTHDATE (mm/dd/yyyy)
			___/___/___

ADDRESS	APT. NO.	CITY	COUNTY	STATE AND ZIP

YOUR E-MAIL ADDRESS *(optional)*	☐ MALE ☐ FEMALE	HOME PHONE NUMBER	WORK PHONE NUMBER	OCCUPATION
		( )	( )	

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED | COMPANY NAME | WORK LOCATION | DATE OF FULL TIME EMPLOYMENT (mm/dd/yyyy) ___/___/___

C. COVERAGE SELECTION - Complete for BCBSNC Health and Dental

COVERAGE: *(Check only one medical plan)*
☐ Blue Care® (HMO) ☐ Blue Options℠ (PPO) ☐ High Plan ☐ Low Plan ☐ Blue Options HSA℠/HRA℠ ☐ High Plan ☐ Low Plan ☐ Classic Blue® (CMM) ☐ Dental Blue

☐ **Medical Benefits Selected:** ☐ Employee Only ☐ Employee and Child(ren) ☐ Employee and Spouse ☐ Employee and Family ☐ No Medical Benefits ☐ Other _____

☐ **Dental Benefits Selected:** ☐ Employee Only ☐ Employee and Child(ren) ☐ Employee and Spouse ☐ Employee and Family ☐ No Dental Benefits ☐ Other _____

D. FAMILY INFORMATION - Complete for anyone taking Medical and/or Dental Coverage

- List family members taking medical or dental.
- Student status and handicapped child information required for all family members who exceed the eligible dependent age maximum in policy documents.

NAME *(First, Middle Initial, Last)*	**SOCIAL SECURITY NUMBER**	**BIRTHDATE**	**SEX**	**HEALTH**	**DENTAL**	**IF CHILD IS OVER AGE 19, PLEASE INDICATE STATUS AND SCHOOL NAME**	**CHILD STATUS** *(if applicable)*
SPOUSE			☐ MALE ☐ FEMALE	☐ YES ☐ NO	☐ YES ☐ NO		
CHILD 1			☐ MALE ☐ FEMALE	☐ YES ☐ NO	☐ YES ☐ NO	☐ Handicapped ☐ Full-time Student at: _____	☐ Foster ☐ Adopted
CHILD 2			☐ MALE ☐ FEMALE	☐ YES ☐ NO	☐ YES ☐ NO	☐ Handicapped ☐ Full-time Student at: _____	☐ Foster ☐ Adopted
CHILD 3*			☐ MALE ☐ FEMALE	☐ YES ☐ NO	☐ YES ☐ NO	☐ Handicapped ☐ Full-time Student at: _____	☐ Foster ☐ Adopted

*If you have more than three children, please complete **Section D** on another application.

Application is continued on reverse side ➡

Employee Name _____

E. OTHER HEALTH INSURANCE INFORMATION AND PRIOR HEALTH INSURANCE INFORMATION

E1. PRIOR HEALTH INSURANCE

*This section **MUST** be completed to receive credit for prior coverage and **REDUCE** or **ELIMINATE** any applicable waiting period.*

BCBSNC will assist in obtaining a certificate of coverage from any prior plan or issuer, if necessary.

Have you had any health insurance within the last sixty-three (63) days? ☐ Yes ☐ No ***IF YES, complete below:***

NAME, ADDRESS AND PHONE NUMBER OF HEALTH INSURANCE COMPANY

POLICYHOLDER NAME	POLICY NUMBER	POLICYHOLDER DATE OF BIRTH (mm/dd/yyyy) ___/___/___
EFFECTIVE DATE (mm/dd/yyyy) ___/___/___	TERMINATION DATE OR EXPECTED TERMINATION DATE (mm/dd/yyyy) ___/___/___	← ***If other coverage will remain in effect, write N/A in term box, and complete section below.***

FAMILY MEMBERS COVERED ***LIST NAMES AND RELATIONSHIPS***:

Have you or any family dependents been a previous Blue Cross and Blue Shield of North Carolina member? ☐ Yes ☐ No

DATES AND ID NUMBER

E2. OTHER HEALTH INSURANCE

*This section **MUST** be completed if you will have additional insurance in force during this new policy.*

Will you or your covered dependents have other insurance in addition to this policy? ☐ Yes ☐ No

Are any dependents covered under another plan due to divorce/separation? ☐ Yes ☐ No ***IF YES TO EITHER QUESTION, complete E2 below***

NAME, ADDRESS AND PHONE NUMBER OF HEALTH INSURANCE COMPANY

POLICYHOLDER NAME AND DATE OF BIRTH (mm/dd/yyyy) ___/___/___	POLICY HOLDER'S SOCIAL SECURITY NUMBER	If Individual coverage check here ☐

POLICYHOLDER'S EMPLOYER, ADDRESS AND PHONE

POLICY NUMBER	EFFECTIVE DATES OF COVERAGE (mm/dd/yyyy) From: ___/___/___ To: ___/___/___

INDIVIDUALS COVERED

FAMILY MEMBERS COVERED BY MEDICARE

MEDICARE CLAIM NUMBER	IS MEDICARE ELIGIBILITY DUE TO: ☐ RENAL DISEASE ☐ AGE ☐ DISABILITY	**PART A** EFFECTIVE DATE (mm/dd/yyyy) ___/___/___	**PART B** EFFECTIVE DATE (mm/dd/yyyy) ___/___/___

F. COVERAGE SELECTION

Underwritten by: ■ Fort Dearborn Life Insurance Company ■ USAble Life for Life, AD&D, Disability *(if offered by employer)*

Coverage Selection:

Your non-medical group insurance program may not include all the benefits listed below. Ask your employer for the details about the benefits available to you, your cost, if any, and whether you will be required to complete a health questionnaire.

Life / AD&D ..... ☐ **Yes** ☐ **No**

Dependent Life ..... ☐ **Yes** ☐ **No**

Weekly Disability ..... ☐ **Yes** ☐ **No**

Long Term Disability ..... ☐ **Yes** ☐ **No**

Supplemental Life / AD&D ..... ☐ **Yes** ☐ **No** **Amount:** _____

☐ **NO BENEFITS SELECTED**

EMPLOYEE SALARY: _____ ☐ WEEKLY ☐ MONTHLY ☐ ANNUAL

Employee Name _____

F. COVERAGE SELECTION (continued)

PRIMARY BENEFICIARY NAME AND ADDRESS ***(REQUIRED)***

RELATIONSHIP	DATE OF BIRTH (mm/dd/yyyy)	SOCIAL SECURITY NUMBER	PERCENT[1]
	____/____/____		

CONTINGENT BENEFICIARY NAME AND ADDRESS ***(REQUIRED)***

RELATIONSHIP	DATE OF BIRTH (mm/dd/yyyy)	SOCIAL SECURITY NUMBER	PERCENT[1]
	____/____/____		

[1] Note: the primary and contingent beneficiary's percentages must equal 100%.

- I understand that if I selected Life that I will be covered by Fort Dearborn Life Insurance Company or USAble Life at the discretion of the employer group *(as indicated above)*.
- I understand that if I am not actively at work as defined in the policy *(coverage listed in Section F of this application)* on the date my coverage would otherwise become effective, my insurance will not begin until the day I meet the policy definition of actively at work. For those coverages I did not elect, I understand that if I choose to enroll at a later date, my cost may be higher and a health questionnaire may be required.
- I hereby designate the above beneficiaries and revoke the appointment of any existing beneficiaries.

X Signature: _____ Date ____/____/____ (mm/dd/yyyy)

G. STATEMENT OF UNDERSTANDING AND AUTHORIZATION

I understand that the benefits for which I (we) will be eligible are those described in the Blue Cross and Blue Shield of North Carolina and/or the life insurance carrier contract and any changes provided for therein.

I understand that BCBSNC and/or the life insurance carrier may, within two years of the date of this application, void or terminate this coverage or deny claims for coverage if incorrect information has been given on this application. If fraudulent misstatements were made, BCBSNC may take legal action at any time.

BLUE OPTIONS HSA/HRA PLANS ONLY:

I understand that if I am applying for Blue Options HSA, BCBSNC takes no responsibility for determining eligibility to contribute to an HSA. Please check with your tax advisor for questions. The HSA/HRA fund is provided to you directly by a separate Administrator that is unaffiliated with BCBSNC. The HSA is not part of the health benefit plan administered by BCBSNC. BCBSNC is not responsible or liable for administration of the fund. Detailed information regarding your HSA/HRA will be provided by that Administrator. I also understand that due to bank regulations, I will be unable to open or deposit money into an HSA if I provide a P.O. Box as my address.

If your employer selects a BCBSNC fund administrator, BCBSNC will share certain personal information about you with such administrator to facilitate the administrator's establishment of your fund. By signing this application, you are authorizing BCBSNC to share pertinent information with the administrator, which may include your name, address, social security number and employer name.

The "Blue Options HSA" product is a High-Deductible Health Plan that qualifies its members to contribute to a Health Savings Account (HSA), unless its members are otherwise ineligible under applicable federal requirements. If unsure about whether ineligible, members should consult a qualified tax advisor.

By signing this application, you are authorizing the fund administrator to establish an HSA fund on your behalf, as of the date corresponding with the effective date of your High Deductible Health Plan with BCBSNC. In order to activate the fund, you will need to provide additional authorization through documents that will be provided to you by the fund administrator.

If you are issued a debit card in connection with your fund, you agree that although BCBSNC's name and marks may be included on the face of the debit card for your convenience, BCBSNC is not responsible or liable for administration of your debit card. The terms and conditions associated with your debit card are governed by your agreement with the bank issuing the card.

I certify that all statements made herein are complete and true to the best of my knowledge and my signature authorizes all sections of this application.

X Employee Signature: _____ Date ____/____/____ (mm/dd/yyyy)